HEALTH FORMS CHECK LIST

☐ Read page titled, “IMPORTANT INFORMATION”

☐ Placed Banner Student ID number and your name on each page.

☐ HEALTH HISTORY FORM must be completed.

☐ IMMUNIZATION FORM (completed) with health care provider signature. This may be signed by any person authorized by law to administer an immunization.

   **IMPORTANT:** Forms other than the AU Health Services’ form will not be accepted and incomplete forms will be returned.

   If you plan to submit proof of immunity by using measles, mumps or rubella titers rather than using vaccination records, you MUST submit actual laboratory results including reference range and the results MUST verify immunity.

☐ INTERNATIONAL STUDENTS must comply with Immunization requirements set forth by New York State law before arrival to Alfred University. Failure to do so may result in the inability to register for classes or create additional costs to you as a student.

☐ TUBERCULOSIS SCREENING form must be completed and signed by health care provider.

☐ PHYSICAL FORM completed and signed by health care provider.

☐ MENINGITIS RESPONSE form completed and signed by student (parent, if under 18) if the Meningitis vaccine has not been received.

☐ COMPLETED FORMS returned on: __________________ to:

   Date

PLEASE DO NOT RETURN THIS CHECKLIST TO AU HEALTH SERVICES; KEEP FOR YOUR REFERENCE.

Health Services at Alfred University
Attention: Health Forms
19 Park Street
Alfred, NY 14802

NOTE: To assure your form is received by health services, please mail it directly to health services at the above address.
Dear Student:

Welcome to Alfred University!

Enclosed you will find the required immunization form, health history form, physical examination form, tuberculosis screening form and Meningococcal Meningitis vaccination response form, to be completed by you and/or your health care provider. Please look these forms over carefully before your visit with your health care provider to help assure proper completion of the forms. A checklist is enclosed to help you be sure you have read and completed all pertinent information. If you are under the age of 18, a parent or guardian will need to provide consent for treatment with each visit to health services. Also be aware that services provided by health services are confidential for all students aged 18 and over; the health center cannot share any information with anyone, including parents, without your informed, written consent for each problem addressed. You will receive a Notice of Privacy Practices addressing protected health information upon your first visit to the AU Wellness Center.

If you were born after January 01, 1957, NYS Public Health Law #2165 requires that we have written documentation of two measles, one mumps and one rubella (MMR) immunization. The documentation must be legible and written/translated in English. Students who do not comply will not be able to register for classes, and will be withdrawn from college and denied attendance to classes. Please keep a copy of your immunization record for your own future needs. It is recommended that all college students consider receiving the Meningitis vaccine prior to entering school. You must complete the enclosed acknowledgement section on the Health History form even if you decide not to receive the meningitis vaccine.

New York State Department of Health and AU Health Services have very specific requirements as to what constitutes an acceptable record of immunization. If you have any questions or concerns as to whether the immunization record you are submitting will comply, please call AU Health Services at 607-871-2400.

There are options regarding payments for services provided at AU Health Services. Please note that billing for private insurances is the sole responsibility of the student or his/her family. Itemized statements for private insurance billing are available to students upon request.

The AU Health Services Team looks forward to the opportunity to help you with your health and wellness needs during the academic year. Students are encouraged to maintain a relationship with a primary healthcare provider who can provide and coordinate health care year round. To run Health Services more efficiently, we find that working on an appointment basis is beneficial to both students and health center operations. Except in the event of an emergency, please call in advance to schedule an appointment.

In closing, we hope your experience at Alfred University is a fulfilling and healthy one. We welcome any questions you or a parent may have. Feel free to contact us at any time.

The AU Health Services Team

Return Completed Form To:
Health Services at Alfred University
Attention: Health Forms
19 Park Street
Alfred, NY 14802
Phone: (607) 871-2400
Fax: (607) 871-2631

Further information and links to these forms can be found @ http://www.alfred.edu/students_services/health_services.html

Please Note: The Immunization Form and the Meningitis Response Form should be received by July 15th and must be on file before student can register for classes.
All other forms must be received at least 30 days prior to the start of classes.
AU WELLNESS CENTER
HEALTH SERVICES

Meningococcal Meningitis

What is meningitis?
Meningitis is an inflammation of the lining surrounding the brain and spinal cord; it may be caused by either a virus or bacteria.

Viral meningitis is mainly uneventful, usually does not require any treatment, is more common, and typically occurs in the late summer or early fall. Since this is a virus, antibiotics are not effective and contacts of the person do not require any treatment.

Bacterial meningitis always presents a serious health threat. If left untreated, initial symptoms can progress quickly to coma and death, sometimes as quickly as 12-48 hours. It occurs rarely and sporadically throughout the year, although outbreaks tend to occur in late winter and early spring. In college-aged students, it is most likely caused by the bacterium Neisseria meningitides (known as meningococcal meningitis.) Close contacts need to be treated with preventative antibiotic therapy quickly (preferably within 24 hours.)

How is meningococcal meningitis spread?

It is spread through:

- The air via respiratory secretions (saliva, etc.)
- Oral contact with shared items i.e. cigarettes, drinking glasses, eating utensils
- Intimate contact such as kissing

Symptoms:
- Can resemble flu or other viral respiratory infection
- Is easily misdiagnosed because of similarity to other illnesses
- Most common symptoms include: fever, severe headache, stiff neck, nausea, vomiting, lethargy, confusion, and a rash on extremities that does not blanch when pushed on.

People at Risk:
- Immune system is compromised
- No spleen or one that is operating less than optimal
- Work in a lab or industry that one has the potential exposure to meningitides aerosols
- Travel to hyperendemic areas (sub-Saharan Africa)
- College student living in residence hall setting
- Concurrent respiratory infection, passive/active smoking, bar patronage, excessive ETOH consumption (greater than 15 drinks / week), sharing lipstick, eating utensils, or a mouthpiece on musical instrument.

Is there a vaccine?
Immunization against 4 strains of N. Meningitidis is available and is quite effective. The vaccine takes approximately 10-14 days after receipt to be effective. Adverse effects to the vaccine are mild and infrequent consisting primarily of redness and pain at the injection site lasting 1-2 days. Rarely a fever of short duration can occur. The vaccine is available by appointment at the Crandall Health Center.

Remember, the American College Association recommends that all college students consider vaccination to decrease the risk for a potentially fatal disease.

871.2400
Health Services
at Alfred University
19 Park Street

Created by: Rosetta M. Brown-Greaney, RNC, MSN, NP
April 2000
AU HEALTH SERVICES

IMMUNIZATON FORM

At Alfred University

MUST BE RECEIVED BY HEALTH SERVICES ONE MONTH PRIOR TO START OF CLASSES

Banner ID # A00 __ __ __ __ __

19 Park Street, Alfred, NY 14802

Phone: (607) 871-2400

Name: ____________________________ Date of Birth: ____________________________

Student’s Cell # or phone # where student can be reached: ____________________________

Student’s email address: ____________________________

Students born on or after January 1, 1957 must comply with New York State Public Health Law 2165 requiring immunization dates for measles, mumps, and rubella. All dates should include month, day and year. Forms must be complete, and be typed or printed in the English language.

THIS IS THE ONLY OFFICIAL ACCEPTED FORM.

**Measles (Rubeola):** Two live doses of measles are required. First dose must be given after the first birthday and the second dose must be given after fifteen months of age and at least thirty (30) days after the first dose.

<table>
<thead>
<tr>
<th>MMR: (Combined measles, mumps, rubella) #1 #2</th>
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<tr>
<td>(M / D / Y)</td>
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<td>(M / D / Y)</td>
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Or

Date of first live dose of measles given: ____________________________ (M / D / Y)

Date of second live dose of measles given: ____________________________ (M / D / Y)

Or

Positive measles titer (Copy of result with laboratory reference range must be attached)

**Mumps:** (One mumps dose is required and must be given after the first birthday) Date of live mumps vaccination given: ____________________________ (M / D / Y)

Or

Positive mumps titer (Copy of result with laboratory reference range must be attached)

**Rubella (German Measles):** (One dose is required & must be given after the 1st birthday) Date of live rubella vaccination given: ____________________________ (M / D / Y)

Or

Positive rubella titer (Copy of result with laboratory reference range must be attached)

**Hepatitis B:** (Recommended, not required) #1 Date #2 Date #3 Date (M / D / Y) (M / D / Y) (M / D / Y)

**Hepatitis A:** (Recommended, not required) #1 Date #2 Date (M / D / Y) (M / D / Y)

**Varicella:** #1 Date #2 Date or Date of Disease: ____________________________ (M / D / Y)

(Recommended without other evidence of immunity)

**Meningitis Vaccination:** (Recommended not required) Date: ____________________________ Check One: ☐ Menactra™ ☐ Menomune™ (M / D / Y)

IMPORTANT: Students who have chosen NOT to receive the Meningitis vaccination MUST complete the statement on the Health History Form indicating the vaccine has been declined.

**Tdap:** (Within last 10 years) ____________________________ or **Td** ____________________________ (M / D / Y) (M / D / Y)

**HPV Vaccine:** (Recommended for females) ____________________________ (M / D / Y) (M / D / Y) (M / D / Y)

**Polio:** (Date series was completed) ____________________________ (M / D / Y)

**Healthcare Provider Signature:** ____________________________ (Required) Date: ________________

(Any person authorized by law to administer immunizations)

FOR OFFICIAL USE ONLY:

Immunizations given at AU HEALTH SERVICES

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date</th>
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</table>
MENINGOCOCCAL MENINGITIS VACCINATION RESPONSE FORM

Please read the enclosed information regarding Meningococcal Disease and the availability of a vaccination against this disease. This vaccination is available at AU Health Services for a cost of approximately $140.00 (2009-2010 school year). Please note that NYS Public Health Law requires you to complete the following section on meningococcal meningitis vaccine. You must comply with this law before you can register for classes.

If you have chosen to decline the Meningococcal vaccine, please check the box below and sign on the line indicated.

☐ I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine. I have decided that I (my child) will not obtain immunization against meningococcal meningitis disease. I understand that although I have declined the vaccine at this time, I have the right to request the vaccine at any time in the future. (Note: If you received the meningococcal vaccine available before February 2005 called Menomune™, please note this vaccine’s protection lasts for approximately 3-5 years. Revaccination with the new conjugate vaccine called Menactra™ should be considered within 3-5 years after receiving Menomune™.)

Student Signature (Parent, if under 18) __________________________________________ Date: ____________________________

If you have received the Meningococcal vaccine, this MUST be recorded by your health care provider on the immunization form.

This must be completed: Do you have concerns that you would like to discuss with Health Services staff? ☐ Yes ☐ No
Use separate page to give details of a “YES” response.

Have you ever had: Answer YES or NO

- Allergy to any medications
- Chickenpox (Date ________)
- Hospitalization(s)
- Heart Murmur
- Eating Disorder
- Mental Illness
- Diabetes
- Surgery(s)
- Asthma
- Mononucleosis
- Alcohol/Drug Abuse

CHECK THE FOLLOWING BOXES ONLY IF THEY PERTAIN TO YOU AS A STUDENT………...

☐ AU Health Services is able to provide continuation of some allergy injection programs provided the student is on maintenance doses, only. If you wish to continue an allergy regimen at AU Health Services, please check this box. We will send you additional information regarding our policy and procedure. Provisions must be made with us BEFORE receiving allergy shots at AU Health Services. Students/parents should contact AU Health Services at least two months prior to the beginning of the semester.

Student Signature: __________________________________________ Date: ____________________________

☐ By marking this box, I authorize AU Health Service staff to provide to the Alfred University Counseling and Wellness Center staff, information about me for the purpose of evaluating needs and providing services. I understand that I may be contacted by the Counseling and Wellness Center to further assist me or provide services to me which may be needed for my care. This authorization may include disclosure of information related to alcohol and drug abuse or mental health treatment. I understand this authorization is voluntary and I may revoke this authorization at any time in writing except to the extent that action has already taken place. This authorization does not authorize AU Health Services to discuss my health information or medical care with anyone other than the Alfred University Counseling and Wellness Center.

Student Signature: __________________________________________ Date: ____________________________
For the **HEALTHCARE PROVIDER**: This exam must be completed NOT MORE than SIX MONTHS before the first day of classes. The student will not be allowed to register until AU Health Services receives this form. All information provided by you will be held in strict confidence and will not influence the student’s academic standing at Alfred University.

Date: ___________________________ Name: ___________________________ 
Race (optional): ___________________________

<table>
<thead>
<tr>
<th>HGT: __________ WGT: __________ Build:</th>
<th>Slender</th>
<th>Medium</th>
<th>Heavy</th>
<th>Obese</th>
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</thead>
</table>

Temperature: __________ B/P: __________/________ Pulse: __________

Allergies: ___________________________ Current Medications: ___________________________

Vision: [ ] No Lenses [ ] Lenses R: 20/__________ L: 20/__________ Colorvision: __________ Test Used: __________

If there is a significant health issue that is important for us to be aware of, please describe on a separate sheet and attach.

Check Each Item in Proper Column: (Enter NE if not evaluated)

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head, Neck, Face</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Nose and Sinuses</td>
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<td></td>
</tr>
<tr>
<td>3. Mouth and Throat</td>
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<tr>
<td>4. Teeth and Gingiva</td>
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<tr>
<td>5. Ears</td>
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<tr>
<td>6. Eyes</td>
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<tr>
<td>7. Pupils and Ocular Motion</td>
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<td></td>
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<tr>
<td>8. Lungs, Chest, Breasts</td>
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<td></td>
</tr>
<tr>
<td>9. Heart- include estimate of cardiac function</td>
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<td></td>
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<tr>
<td>10. Vascular System (Varicosities, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>11. Abdomen and Viscera (include hernia)</td>
<td></td>
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<tr>
<td>12. Genital (if appropriate)</td>
<td></td>
<td></td>
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<tr>
<td>13. Ano-rectal (pilonidal)</td>
<td></td>
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<td>14. Endocrine System</td>
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<td>15. G-U System</td>
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<tr>
<td>16. Upper Extremities (strength, ROM)</td>
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<td>17. Feet</td>
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<tr>
<td>18. Lower Extremities</td>
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<tr>
<td>19. Spine, other musculo-skeletal</td>
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<td></td>
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<tr>
<td>20. Skin &amp; Lymphatics</td>
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<td></td>
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<tr>
<td>21. Neurologic</td>
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<tr>
<td>22. Psychiatric (specify)</td>
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</tbody>
</table>

Is there loss or seriously impaired function of any paired organ? [ ] Yes [ ] No [ ] If Yes, Please Explain: ___________________________

Are there any restrictions of physical activity indicated by your exam? [ ] Yes [ ] No [ ] If Yes, Please Explain: ___________________________

Is the student now under treatment for any medical or emotional problem? [ ] Yes [ ] No [ ] If Yes, Please Explain: ___________________________

I have examined the above named student and it is my professional opinion that the student is physically and psychologically able, except as noted above, to undertake college studies.

Examining Healthcare Provider Signature: ___________________________ Print Name: ___________________________

Address/City/State/Zip: ___________________________ Phone: ___________________________ Fax: ___________________________

Email: ___________________________
TUBERCULOSIS SCREENING FORM

1. Has the student ever had a positive PPD test?  □ YES  □ NO
   If NO, proceed to question 2.
   If YES, do not repeat PPD test. Proceed to questions 4-6 and supply information.

2. Does the student have signs or symptoms of active TB disease such as night sweats, weight loss, persistent cough or bloody sputum?  □ YES  □ NO
   If NO, proceed to question 3.
   If YES, proceed with additional evaluation to rule out active TB disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated, questions 3-6.

3. Is the student a member of a high-risk group** or is the student entering the health professions? (See below)  □ YES  □ NO

   **Categories of high-risk students include those students who have arrived within the past five years from countries where TB is endemic. It is easier to identify countries of low rather than high TB prevalence. Therefore, students should undergo TB screening if they have arrived from another country with the EXCEPTION of Canada, Jamaica, Saint Kitts and Nevis, Saint Lucia, USA, Virgin Islands (USA), Belgium, Denmark, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Liechtenstein, Luxembourg, Malta, Monaco, Netherlands, Norway, San Marino, Sweden, Switzerland, United Kingdom, American Samoa, Australia or New Zealand. Other categories of high-risk students include those with HIV infection, who inject drugs, who have resided in, volunteered in or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; those who have had contact with a known case of TB; and those who have clinical conditions such as diabetes, chronic renal failure, leukemias or lymphomas, low body weight, gastrectomy and jejunoileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy (e.g. prednisone ≥15 mg/d for ≥1 month) or other immunosuppressive disorders.

   If NO, STOP! No further evaluation or skin test is needed at this time. Healthcare Provider, please sign below.

   If YES, place tuberculin skin test. (Mantoux only: Inject 0.1ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermal into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.

4. Tuberculin Skin Test:
   Date given: _____/_____/_____
   Date read: _____/_____/_____
   Record actual mm of induration, transverse diameter; if no induration, write “0”
   Result: ______ mm Interpretation: □ Positive □ Negative (based on mm of induration as well as risk factors)

5. Chest X-ray (required if tuberculin skin test is positive): Date of chest x-ray _____/_____/_____
   Result: □ Normal □ Abnormal

6. History of any previous treatment: (Please list medications used and dates of treatment duration)

Healthcare Provider Signature: ____________________________________________________

*Based on recommendations by the American College Health Association (ACHA), Centers for Disease Control and the American Thoracic Society.